


Prevalence of Postpartum Blues and Associated Factors in a Reference University Hospital in Benin

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How to cite this paper: Dossou, A.J.E., Otti, A., Alladogansi, J. and Sossa, J.C. (2025) Prevalence of Postpartum Blues and Associated Factors in a Reference University Hospital in Benin. *Journal of Biosciences and Medicines*, 13, 444-458. <https://doi.org/10.4236/jbm.2025.1311032>

Received: October 22, 2025

Accepted: November 23, 2025

Published: November 26, 2025

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Abstract

Postpartum blues (PPB) is a common emotional disorder in women after childbirth, which can impact their well-being and that of the newborn. Few studies have explored its prevalence and associated factors in the Beninese context. The objective was to determine the prevalence of PPB and associated factors at the Lagune University Hospital for Mothers and Children (CHU-MEL) in Benin. A mixed descriptive design with analytical aims was adopted. Roy's adaptation model served as the conceptual framework for the study. Data were collected in July 2025 from women who had given birth, selected by a non-probabilistic convenience method using the French version of the "Maternity Blues Questionnaire" by Kennerley and Gath, to which was associated a specific questionnaire composed of sociodemographic and obstetric variables. A woman was declared to have BPP when she answered at least 12 times to the 28 items of the questionnaire (threshold score set at 12). Factors associated with the occurrence of BPP were identified using Pearson's Chi² test or Fisher's exact test ($p < 0.05$) using JAMOVI statistical software version 2.6.26. Seventy-one women were included in the study. Their mean age was 28.2 ± 6.12 years. The prevalence of BPP was estimated at 52.1% (95% CI: 40.5 - 63.7) with a peak occurring on postpartum day 1. The main significantly associated factors were postpartum complications ($p = 0.013$) and difficulties in feeding the newborn ($p = 0.028$). The results of the study highlight the importance of integrating systematic screening for BPP in postpartum women and providing psychological support, particularly for women at risk.

Keywords

Postpartum Blues, Prevalence, Contributing Factors, CHU-MEL, Benin

1. Introduction

The postpartum period is a phase of significant upheaval in women's lives, marked by profound physical, emotional, and social changes [1]. In the days following childbirth, the majority of women experience mood fluctuations grouped under the term Postpartum Blues (PPB) [2]. Long considered benign, PPB shares several determinants with Postpartum Depression (PPD), and a clear link between these two entities has been established [3]. It is now recognized that PPB constitutes a specific risk factor for the development of PPD, Postpartum Psychosis (PPP), and for long-term emotional and cognitive disorders in both the mother and child.

Globally, the prevalence of PPB varies significantly depending on geographical, cultural, and socio-economic contexts. For example, on the Asian continent, it has been estimated at 50% - 80% in Iran, 58% in India, and 70.3% in Korea [4], with extremes ranging from 3.5% in Malaysia to 63.3% in Pakistan [5]. In Western countries, PPB rates also vary: 58% to 67% in the United States, 10% to 14% in Canada, and 55.2% in Europe [5]. In Africa, the prevalence is among the highest, reaching approximately 49.6% [6].

In Benin, data on postpartum blues (BPP, hereinafter) remain scarce, despite the specific difficulties faced by women in the postpartum period, particularly their limited access to mental health care. Hospital facilities rarely provide comprehensive and high-quality maternal care, defined as effective, continuous, accessible, and safe care [7]. Furthermore, postpartum blues, an acute mood disorder that most commonly manifests between the third and tenth day after childbirth, remain underrecognized or even trivialized [8] [9]. Few recent studies have focused on understanding this phenomenon in Benin, from the perspectives of the affected women, their social circles, or healthcare providers [5]. However, without appropriate management, postpartum blues can progress to more severe psychological disorders, such as postpartum depression (DPP), with significant impacts on the health of the mother, the newborn, and the family unit [10].

In the Beninese context, several obstacles limit access to postnatal care: rural poverty, illiteracy, transportation costs, cultural taboos, a shortage of personnel, and inadequate reception quality in services [11] [12]. These factors, combined with cultural beliefs influencing emotional expression and help-seeking behavior, could play a major role in the occurrence of postpartum blues (BPP). The absence of reliable local data on the prevalence and determinants of BPP complicates the development of appropriate prevention and support strategies. Therefore, it is necessary to document this issue within the Beninese context to fill this gap. A better understanding of the prevalence and associated factors of BPP will not only

help identify women at risk but also guide healthcare professionals toward more targeted interventions, thereby enhancing the quality of postnatal follow-up.

What is the prevalence of BBP at the Lagune University Hospital for Mothers and Children (CHU-MEL) in Cotonou in the Republic of Benin, and what are the factors that promote its occurrence in postpartum women?

2. Materials and Methods

2.1. Research Design and Framework of the Study

A descriptive study with two components (quantitative and qualitative) for analytical purposes was conducted in July 2025. The qualitative component provided insight into the perceptions, emotional experiences, and psychosocial factors that could be associated with postpartum blues. This qualitative approach enriched the overall analysis and made it possible to interpret the statistical associations by incorporating subjective and social dimensions, which strengthened the validity of the conclusions regarding the associated factors.

An analytical descriptive mixed-methods study was conducted in July 2025. Roy's Adaptation Model [13] served as the conceptual reference framework. Indeed, this model [13] is a nursing theory that views the individual as an integrated whole in constant interaction with the environment, possessing innate or acquired adaptation mechanisms (biological, psychological, or social) to maintain integrity, which can be enhanced through nursing interventions.

According to Roy [13], the factors influencing adaptation are focal, contextual, and residual stimuli. The focal stimulus represents the degree of change or stimulus that the person is facing immediately and must adapt to; it triggers the behavior. The object or event in question is foremost in the person's mind. The contextual stimulus refers to all other factors present in the situation that will influence the focal stimulus, but are not the center of attention or energy expenditure. Finally, the residual stimulus entails all factors that may influence behavior but whose effects are impossible to verify [13]. In response to the stimuli, the person will adopt innate or acquired coping mechanisms distributed across four modes [13]:

- The physiological mode: it concerns the physical and biochemical interaction of the body with the environment and includes five needs (oxygenation, nutrition, elimination, activity and rest, protection and means of defense) and four processes (senses, fluids and electrolytes, neurological function, endocrine function);
- The self-image mode: it focuses on the psychological and spiritual aspects of the individual, including feelings of value, meaning in life, and consistency between beliefs and actions;
- Role function mode: it concerns the various social roles that the individual occupies, including family, professional, gender, and societal roles;
- The interdependence mode: It involves interactions with others by giving and receiving love, respect, and value.

The elements of adaptation of the Roy model [13] under study are presented in **Table 1**.

Table 1. Elements of adaptation of the Roy14 model under study.

No.	Constituent elements of the conceptual framework of reference for the study	Description	Elements of adaptation to the study (Stimuli to be assessed in the woman giving birth: modalities of the variables under study)
1	Focal stimuli	Degree of change or stimulus that the person immediately faces and must adapt to; this element triggers the behavior.	<ul style="list-style-type: none"> • Mode of delivery, • Condition of the newborn, • Due date, • Feeding difficulties in the newborn, • Postpartum complications, • Feeding method of the newborn, • Quality of postpartum care.
2	Contextual stimuli	Factors present in the situation that will influence the focal stimulus, but which are not the center of attention or energy expenditure.	<ul style="list-style-type: none"> • education level, • religion, • occupation, • desire for pregnancy, • marital conflict, • Support from family and friends, • complications during pregnancy, • Sex of the baby, • ethnicity, • marital status, • age, • cohabitation with partner, • parity.
3	Residual stimuli	Factors that can influence behavior, but whose effects cannot be verified.	<ul style="list-style-type: none"> • Previous experiences of childbirth, <ul style="list-style-type: none"> ○ fear, ○ verbal abuse, ○ positive or negative trauma, ○ stories, ○ beliefs.

The reaction of the mother to these stimuli can be observed through the four modes of adaptation of the Roy model [13] as follows:

- physiological: fatigue, sleep disturbances, hormonal imbalance;
- self-image: low self-esteem, anxiety, sadness;
- role function: difficulty fully assuming the role of mother;
- interdependence: social isolation.

All of these coping strategies ultimately lead to BBP, which in our case is an inappropriate response. The nursing objective, in this context, is to promote positive coping by identifying stimuli that are detrimental to the mothers' well-being and by proposing interventions focused on the specific needs of each woman.

2.2. Data Collection and Analysis Methods

Data were collected from postpartum women hospitalized in the maternity recovery and hospital units of CHU-MEL in Cotonou, Benin, selected through non-probability convenience sampling from the day of delivery until the day of their discharge from the maternity ward. The sample size, limited to 71 women who had given birth, was determined by the two-week recruitment period for participants who made themselves available at this hospital. This size allowed for a descriptive estimate with sufficient accuracy for an exploratory study, although it did not guarantee the statistical power required for all analyses. Furthermore, the choice of a convenience sample, limited to a single site over a short period of time, restricts the generalizability of the results to other contexts, which is a recognized limitation of the external validity of the study. Excluded from the study were women who experienced intrauterine fetal death or medical termination of pregnancy, as well as those whose newborn had died at the time of data collection.

The French version [14] of the “Maternity Blues Questionnaire” by Kennerley and Gath [15], coupled with a specific questionnaire composed of sociodemographic and obstetric variables, was the primary standard evaluation tool for Postpartum Blues used for data collection [16]. This tool includes 28 items designed to detect the presence and intensity of the main symptoms of PPB. The items allow women to describe what they feel (examples: “Irritable,” “Feel like crying,” “Mood swings”) by first responding “Yes” or “No” to the item, and then using a five-point Likert scale to rate the intensity of their feelings compared to usual, ranging from “much less than usual” to “much more than usual.” This dual response (absence/presence and intensity) places the surveyed postpartum women on a continuum, thus avoiding a categorical treatment of PPB. The maximum score was 28, and the minimum score was zero (0). A postpartum woman was declared to have PPB when she responded affirmatively to at least 12 out of the 28 items (threshold score set at 12) [9]. The threshold of “≥ 12 positive responses” used as a diagnostic criterion is based on the original validation of the Maternity Blues Questionnaire (MBQ), which is recognized as indicating the significant presence of baby blues. The French version of the MBQ has been adapted and validated in French-speaking contexts, but its specific validation in Benin remains to be confirmed, which somewhat limits the generalization of the results. Using the JAMOVI statistical software version 2.6.26, factors associated with the occurrence of PPB were identified using Pearson’s Chi² test or Fisher’s exact test when the conditions for Pearson’s Chi² test were not met (expected counts > 5), with a significance level set at 5% ($p < 0.05$). Next, variables with a p-value of less than 20% in bivariate analysis were entered into a stepwise downward multiple logistic regression model. Variables with a p-value greater than or equal to 5% were progressively eliminated until the final model was obtained, which contained only variables with a p-value of less than 5%. The adequacy of the final model was verified using the Hosmer-Lemeshow test. The final model was considered adequate when the p-value was below the 5% threshold.

Our study is part of an epidemiological research project aimed at investigating the prevalence of BPP and associated factors. It was conducted in accordance with ethical and professional standards. Articles 20 and 21 of Law No. 2010-40 of December 8, 2010, relating to the code of ethics and professional conduct for health research in the Republic of Benin, and in accordance with the principles of the current version of the Declaration of Helsinki, specifically Title III: Conditions for Conducting Health Research, Chapter 1: Epidemiological Research, specify the following: Article 20: Any epidemiological research applied to a group of individuals or a community must be subject to prior agreement by their legal representatives. Thus, authorization to collect data was obtained from the Administration of the National Institute of Health and Medical Research, registered under number 153. Article 21: The informed consent of persons participating in any epidemiological research is mandatory. Thus, for this study, data were collected with the free and informed consent of each participant. Participation in this study was strictly voluntary.

3. Results

3.1. Sociodemographic and Sociocultural Characteristics of Women Who Have Given Birth

The distribution of women who gave birth according to their sociodemographic and sociocultural characteristics is presented in **Table 2**.

Table 2. Distribution of women who gave birth according to their sociodemographic and sociocultural characteristics (n = 71).

Sociodemographic and sociocultural variables	Modalities	Effective	%
Age	15 - 24	18	25.4
	25 - 34	40	56.3
	35 and over	13	18.3
Marital Status	Common-law union	63	88.7
	Married	8	11.3
Education Level	Not in school	12	16.9
	Primary	15	21.1
	Secondary	31	43.7
	University	13	18.3
Occupation	Craftswomen, traders	53	74.6
	Executives and higher intellectual professions	03	4.2
	Employees	2	2.8
	Intermediate professions	4	5.6
	Not working	9	12.7

Continued

Ethnicity	Fon	35	49.3
	Goun	11	15.5
	Adja	5	7
	Nago	9	12.7
	Autres	11	15.5
Religion	Christianity	64	90.1
	Islam	7	9.9

Seventy-one postpartum women were included in the study. Their mean age was 28.2 ± 6.12 years, with a range from 17 to 42 years. The most common age group was [9]-[17] ($n = 40$, accounting for 56.3%). In terms of marital status, the vast majority of postpartum women were in a common-law relationship (88.7%). The majority of respondents had a secondary level of education (43.7%), and more than half of them (74.6%) were artisans and traders. Additionally, Christianity (90.1%) was the most practiced religion among the respondents, and nearly half of them (49.3%) were of the “Fon” ethnicity.

3.2. Obstetric Characteristics of Women Who Have Given Birth

The obstetric characteristics of the women surveyed are recorded in **Table 3**.

Table 3. Distribution of women who gave birth according to their obstetric characteristics ($n = 71$).

Obstetric variables	Modalities	Effective	%
Parity	Primiparous	21	29.6
	Multiparous	50	70.4
Mode of Delivery	Low voice	23	32.4
	Caesarean section	48	67.6
Sex of the Newborn	Male	34	47.9
	Female	37	52.1
Condition of the Newborn	Good	65	91.5
	Bad	6	8.5
Delivery Date	Premature	14	19.7
	Full term	57	80.3
Feeding of the Newborn	Exclusively breastfeeding	61	85.9
	Formal breastfeeding	6	8.5
	Combined breastfeeding	4	5.6

The majority (70.4%) of the postpartum women were multiparous, with an average parity of 2.34 children. A total of 67.6% had given birth via cesarean section, and the gender distribution of newborns was relatively balanced (52.1% girls and 47.9% boys). The overall health status of newborns at birth was deemed satisfactory in 91.5% of cases. Additionally, 19.7% of the births were preterm.

3.3. Prevalence of BPP in Postpartum Women

Table 4 below shows the distribution of women according to the number of “yes” responses to the MBQ items.

Table 4. Distribution of women according to the number of “yes” responses to MBQ items (n = 71).

Number of “Yes” responses to the 28 items of the “Maternity Blues Questionnaire” by Kennerley and Gath [9] [15]	Effective	%
≥12	37	52.1
<12	34	47.9
Total	71	100

Of the 71 women surveyed, 37 answered “yes” to the MBQ items at least 12 times, or 52.1%, and were therefore women with BPP.

Table 5 below shows the distribution of BPP among women according to their postpartum days at the time of the survey.

Table 5. Distribution of BPP among women according to their postpartum days at the time of the survey (n = 71).

Postpartum days	Blues (%)	No blues (%)	Total (%)
J0	4 (57.1)	3 (42.9)	7 (100)
J1	13 (68.4)	6 (31.6)	19 (100)
J2	5 (33.3)	10 (66.7)	15 (100)
J3	7 (46.7)	8 (53.3)	15 (100)
J4 et plus	8 (53.3)	7 (46.7)	15 (100)
Total	37 (52.1)	34 (47.9)	71 (100)

Analysis of Table V shows that more than half (57.1%) of the women surveyed on D0 (n = 07) presented BPP. This rate increases on D1 (68.4%), decreases on D2 (33.3%), before stabilizing in the following days. These results indicate an early worsening of symptoms in the first 24 hours after delivery and that it can persist for several days.

3.4. Factors Associated with the Occurrence of BPP in Postpartum Women Included in the Study

3.4.1. Sociodemographic Factors

The elements of the analysis of the influence of sociodemographic and sociocultural characteristics on the BPP are presented in **Table 6**.

Table 6. Frequency of BPP or not according to the sociodemographic and sociocultural characteristics of the women who gave birth (n = 71).

Socio-demographic variables	Modalities	Blues (%)	No blues (%)	Total (%)	p-value
Age	15 - 24	10 (55.6)	8 (44.4)	18 (100)	0.917
	25 - 34	20 (50.0)	20 (50.0)	40 (100)	
	35 et plus	7 (53.8)	6 (46.2)	13 (100)	
Marital Status	Common-law union	35 (55.6)	28 (44.4)	63 (100)	0.103
	Married	2 (25.0)	6 (75.0)	8 (100)	
Education Level	Not in school	8 (66.7)	4 (33.3)	12 (100)	0.448
	Primary	8 (53.3)	7 (46.7)	15 (100)	
	Secondary	13 (41.9)	18 (58.1)	31 (100)	
	University	8 (61.5)	5 ((38.5)	13 (100)	
Occupation	Craftswomen, tradeswomen	24 (45.3)	29 (54.7)	53 (100)	0.275
	Executives and higher intellectual professions	3 (100.0)	0 (0.0)	3 (100)	
	Employees	1 (50.0)	1 (50.0)	2 (100)	
	Intermediate professions	3 (75.0)	1 (25.0)	4 (100)	
	Not working	6 (66.7)	3 (33.3)	9 (100)	

Analysis of **Table 6** reveals that no sociodemographic variable was significantly associated with PPB (all $p > 0.05$). However, postpartum women in a common-law relationship exhibited PPB more frequently (55.6%) compared to those who were married (25%). Similarly, PPB appeared more common among unschooled women (66.7%) and those without professional activity (66.7%) than in other categories, although these differences were not statistically significant. Age did not appear to influence the occurrence of PPB.

3.4.2. Factors Related to Obstetric Characteristics

Table 7 below presents the frequencies of BPP according to the obstetric characteristics of the women who gave birth.

Analysis of the data in **Table 7** shows that the obstetric characteristics of the respondents did not show any statistically significant links with the occurrence of BPP. However, BPP was slightly more present in multiparous women (57.1%)

than in primiparous women (50%) and was more frequent after a vaginal delivery (60.9%) than after a caesarean section (47.9%). Similarly, a higher frequency of BPP (83.3%) was noted in women whose newborns were considered to be in poor condition. Sex, term of birth, and the feeding method of the newborn did not show any significant influence.

Table 7. Frequency of BPP or according to the obstetric characteristics of the women who gave birth (n = 71).

Obstetric characteristics	Modalities	Blues (%)	No blues (%)	Total (%)	p-value
Parity	Primiparous	25 (50.0)	25 (50.0)	50 (100)	0.582
	Multiparous	12 (57.1)	9 (42.9)	21 (100)	
Mode of Delivery	Low voice	14 (60.9)	9 (39.1)	23 (100)	0.307
	Caesarean section	23 (47.9)	25 (52.1)	48 (100)	
Sex of the Newborn	Male	18 (52.9)	16 (47.1)	34 (100)	0.893
	Female	19 (51.4)	18 (48.6)	37 (100)	
Condition of the Newborn	Good	32 (49.2)	33 (50.8)	65 (100)	0.110
	Bad	5 (83.3)	1 (16.7)	6 (100)	
Delivery Date	Premature	8 (57.1)	6 (42.9)	14 (100)	0.674
	Full term	29 (50.9)	28 (49.1)	57 (100)	
Feeding of the Newborn	Allaitement Exclusively breastfeeding	31 (50.8)	30 (49.2)	61 (100)	0.875
	Formal breastfeeding	4 (66.7)	2 (33.3)	6 (100)	
	Combined breastfeeding	2 (50.0)	2 (50.0)	4 (100)	

3.4.3. Other Characteristics Studied among the Respondents

Table 8 below presents the frequencies of BPP or not according to the other characteristics studied in the women who gave birth.

Table 8. Frequencies of BPP or not according to the other characteristics studied in women who gave birth.

Other characteristics studied among the respondents	Modalities	Blues (%)	No blues (%)	Total (%)	p-value
Cohabitation with Partner	Yes	25 (49.0)	26 (51.0)	51 (100)	0.405
	No	12 (60.0)	8 (40.0)	20 (100)	
Desire for Pregnancy	Strong	13 (41.9)	18 (58.1)	31 (100)	0.131
	Weak	24 (60.0)	16 (40.0)	40 (100)	
Marital Conflict	Yes	14 (60.9)	9 (39.1)	23 (100)	0.307
	No	23 (47.9)	25 (52.1)	48 (100)	
Support from Family and Friends	Good	22 (46.8)	25 (53.2)	47 (100)	0.211
	Weak	15 (62.5)	9 (37.5)	24 (100)	

Continued

Complications During Pregnancy	Yes	14 (60.9)	9 (39.1)	23 (100)	0.307
	No	23 (47.9)	25 (52.1)	48 (100)	
Previous Childbirth Experiences	Good	19 (48.7)	20 (51.3)	39 (100)	0.733
	Bad	6 (54.5)	5 (45.5)	11 (100)	
Quality of Postpartum Care	Good	21 (51.2)	20 (48.8)	41 (100)	0.705
	Bad	16 (53.3)	14 (46.7)	30 (100)	
Postpartum Complications	Yes	11 (84.6)	2 (15.4)	13 (100)	0.013
	No	26 (44.8)	32 (55.2)	58 (100)	
Newborn Feeding Difficulties	Yes	14 (73.7)	5 (26.3)	19 (100)	0.028
	No	23 (44.2)	29 (55.8)	52 (100)	

It appears from the analysis of the data in **Table 8** that postpartum complications ($p = 0.013$) and difficulties in feeding the newborn ($p = 0.028$) were significantly associated with the occurrence of BPP. As for the other factors, they were not significantly associated with the occurrence of BPP, despite the fact that BPP is more frequent in women with a “low desire for pregnancy” (60%), in a “situation of marital conflict” (60.9%), with “low support from those around them” (62.5%), or having had “complications during pregnancy” (60.9%).

Multivariate analysis

We used a stepwise logistic regression method. All variables that were significantly associated with the 20% threshold in univariate analysis were retained to form our first multivariate model. At each stage, the variable with the highest p-value was eliminated until all variables significantly associated with the 5% threshold were obtained at the ninth stage (**Table 9**).

Table 9. Final model of the multivariate analysis from the logistic regression.

Variables	OR	IC _{95%}	p
Age	1.04	[0.95, 1.14]	0.339
Occupation	1.60	[1.03, 2.49]	0.036
Marital status	0.18	[0.03, 1.22]	0.079
Level of education	0.74	[0.39, 1.38]	0.345

Occupation was the only sociodemographic factor to have a statistically significant influence on the risk of BPP. Adjusted for the other variables in the model, midwives who were not working were at greater risk (OR = 1.60; 95% CI = [1.03 - 2.49]) of having BPP.

4. Discussion

Roy's model [13] has been useful in understanding how mothers cope with changes and stresses related to the postpartum period and how certain factors influence their psychological well-being through the occurrence of postpartum blues. As a focal stimulus immediately disrupting the woman's adaptation after childbirth, postpartum complications affect the physiological mode (fatigue and pain) and the self-image mode (fear, feeling of having brushed with death), which weakens the woman's emotional balance.

The results of the study showed that 67.6% of mothers had undergone a cesarean section, 19.7% of babies were born prematurely, and difficulties in newborn feeding were significantly associated with the occurrence of PPB ($p = 0.028$). All these factors are part of the physiological mode of Roy's model [13], where the physical health of the mother and the baby represents internal stimuli (physiological: sleep disturbance, fatigue), as well as postpartum complications (significant factor with $p = 0.013$) faced by the mother, which are elements affecting the adaptation capacity postpartum. The feeling of fear and difficulties in feeding the newborn are considered focal stimuli that disrupt the self-image mode (anxiety related to child feeding), thereby increasing the risk of PPB occurrence. Experiences during previous childbirths can be considered residual stimuli, acting silently, reactivating fear, stress, and distrust, and affecting self-image and role function. This mode reflects the importance of internal psychological factors related to self-control in the face of stress, emotions, and previous experiences that affect maternal psychological adaptation. As for the role function mode, it explored the woman's ability to adapt to the expectations, responsibilities, and relational changes that accompany motherhood. The analysis of facilitating factors did not show any statistically significant association with the studied variables. This result suggests that in our context, the sociodemographic and obstetric variables considered were not sufficient to explain the observed variations in adaptation to the maternal role postpartum but could be influenced by more subjective and contextual dimensions that escaped the addressed variables. In summary, the absence of a significant link observed in this study does not undermine the relevance of Roy's [13] role function mode, but rather highlights the richness and complexity of the maternal adaptation process, aligning with the analysis framework that asserts it is not the factor that determines the adaptation response, but the way it is perceived or experienced by each woman.

In short, this study illustrates the relevance of Roy's model [13] by showing that postpartum blues can be understood as a multidimensional adaptation response to the numerous stimuli encountered after childbirth, notably physiological (health status of the newborn, complications), psychosocial (profession, marital cohabitation), and emotional (previous obstetric experiences), hence the need for holistic support for mothers, taking into account all these different dimensions to promote their adaptation and prevent or reduce the prevalence of postpartum blues.

The majority of the women surveyed were young (mean age: 28.2 ± 6.12 years), living in a common-law relationship (88.7%) with a predominance of craftswomen and traders (74.6%). These results corroborate those of Landman *et al.* [17] who found in their study a population similar in age, marital status, and employment level. On the cultural level, the predominance of the “Fon” ethnic group (49.3%) and the Christian religion (90.1%) in our study population is in line with the data reported by Faisal-Cury *et al.* [18], where the majority of patients were also Christian (73.5%). These cultural factors are not, in reality, trivial, because, as Akbarzadeh *et al.* [4] show, religious beliefs and spiritual teachings can play a protective role by modulating the perception of postpartum baby blues and promoting positive attitudes towards maternal challenges. On the obstetric level, the predominance of multiparous women (70.4%) observed in our study corroborates the results of the work of Gerlone *et al.* [19], which indicated a proportion of 81% of multiparity in their study population. Note that unlike certain contexts where artificial breastfeeding is preferred, 85.9% of the women in our study chose exclusive breastfeeding, which can have positive implications for the mother-child bond and psychological well-being. Furthermore, the high incidence of caesarean section cases (67.6%) could be explained by the fact that the study setting is a gynecological-obstetric reference center receiving complex cases. The prevalence of BPP in our study population was 52.1% (95% CI: 40.5 - 63.7). This rate is within the range of prevalences reported by Rezaie-Keikhaie *et al.* [6] in their systematic review, but above the prevalence found in a study conducted in Nigerian women by Adewuya *et al.* [20]: 31.3%. Postpartum complications were significantly associated with the occurrence of BPP in the women who gave birth ($p = 0.013$) included in our study, which corroborates the results of the Andrade *et al.* study [21]. The same is true for newborn feeding difficulties, which were also significantly associated with the occurrence of BPP ($p = 0.028$), which further confirms the idea of Andrade *et al.* [21], who believe that breastfeeding difficulties were risk factors for the occurrence of BPP.

5. Conclusion

The results of the study showed that BPP was observed in 52.1% of the women surveyed who gave birth and that symptoms worsened in the first 24 hours after delivery, thus confirming the importance of this disorder in the Beninese context. Factors significantly associated with the occurrence of BPP among the respondents include postpartum complications ($p = 0.013$) and difficulties in feeding the newborn ($p = 0.028$). Despite the limitations related to the sample size ($n = 71$) and the fact that data collection was limited to a single university hospital (CHU-MEL of Cotonou), this study highlights the need to strengthen support for women after childbirth, particularly during the first critical days when the risk of postpartum blues is highest. This involves systematizing early screening for PPB and integrating targeted interventions to support the mental health of mothers, particularly those with identified risk factors. These results call for the implementation of policies

and programs aimed at raising awareness among health professionals, but also among families, of the importance of this multidimensional support. Holistic postnatal monitoring, taking into account physiological, psychosocial, and emotional aspects, will contribute not only to improving the individual well-being of mothers, but also to preventing long-term consequences on maternal mental health, with positive repercussions on child development and family dynamics.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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